TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Pine Creek Medical Center

Respondent Name
Liberty Mutual Fire Insurance

MFDR Tracking Number
M4-16-1429-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
January 28, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In additional to the above mentioned CPT code implants are to be paid as well."

Amount in Dispute: $4,950.04

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Implants were billed. Separate payment was requested. Although we received implant invoices and an attestation statement, the Operative Report did not specify the number of implants used..."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 17, 2015	Revenue Code 278	$4,950.04	$4,950.04

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - X313 – We are unable to review this charge(s) without the operative report for all surgical procedures and for each surgeon, if dictated separately
   - 16 – X936 – CPT or HCPC is required to determine if services are payable
   - 193 – original payment decision is being maintained

- W3 – Additional payment made on appeal/reconsideration

Issues

1. Are the insurance carrier's position statement supported?
2. What is the additional recommended payment for the implantable items in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier states in the position statement, "the Operative Report did not specify the number if implants used and a denial requested the implant log…" Review of the submitted information finds the requestor submitted an invoice that states "Invoice Comments: 031715/Patel." Review of the submitted operative report finds the "Operative Report" shows date of operation, 3/17/2015, Surgeon: Nilpesh Patel, M.D." The insurance carrier's position is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.
2. This dispute regards outpatient hospital facility services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403(f) which states,

> The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
>
> (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
>
> (A) 200 percent; unless
>
> (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

Review of the submitted documentation finds that separate reimbursement for implantables was requested. The facility's total billed charges for the separately reimbursed implantable items are $22,950.00.

3. Per §134.403(g), "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission." Review of the submitted documentation finds that the separate implantables include:

- "Imp stry k-wire" as identified in the itemized statement and labeled on the invoice as "K wire 17mm" with a cost per unit of $18.97;
- "imp stry bone filler 2.5cc" as identified in the itemized statement and labeled on the invoice as "Vitoss bbtrauma foam back 2.5cc" with a cost per unit of $1,049.40;
- "imp stry scr 2. x 14mm t7" as identified in the itemized statement and labeled on the invoice as "bone screw t7 2.7x14mm" with a cost per unit of $74.83 at 4 units, for a total cost of $299.32;
- "imp stry scr 2.7 x 16mm t7" as identified in the itemized statement and labeled on the invoice as "bone screw 57 2.7x16mm" with a cost per unit of $74.83;
- "imp stry scr 2.7 x 20mm t7" as identified in the itemized statement and labeled on the invoice as "bone screw 77 2.7x20 mm" with a cost per unit of $74.83;

- "imp stry scr 2.7 x 16mm locking" as identified in the itemized statement and labeled on the invoice as "locking screws t7 2.7x16mm" with a cost per unit of $85.52 at 2 units, for a total cost of $171.04;
- "imp stry scr 2.7 x 18mm locking" as identified in the itemized statement and labeled on the invoice as "locking screws t7 2.7x18mm" with a cost per unit of $85.52;
- "imp stry plt 7 hole" as identified in the itemized statement and labeled on the invoice as "variax straight plate 7 hole" with a cost per unit of $451.00;
- "imp stry scr 2.7 x 14mm locking" as identified in the itemized statement and labeled on the invoice as "locking screws t7 2.7x14mm" with a cost per unit of $85.52;
- "imp stry scr 2.7 x 18mm t7" as identified in the itemized statement and labeled on the invoice as "bone screw t7 2.7x18mm" with a cost per unit of $74.83;
- "imp stry scr 3.5 x 16mm t10" as identified in the itemized statement and labeled on the invoice as "bone screw t10 3.x16mm" with a cost per unit of $57.73 at 3 units, for a total cost of $173.19;
- "imp stry scr 3.5 x 18mm t10" as identified in the itemized statement and labeled on the invoice as "bone screw g10 3.5x18mm" with a cost per unit of $57.73;
- "imp stry scr 3.5 x 16mm locking" as identified in the itemized statement and labeled on the invoice as "locking screw t10 x 3.5x16mm" with a cost per unit of $115.47;
- "imp stry pscr 3.5 x 18mm locking" as identified in the itemized statement and labeled on the invoice as "locking screw t10 3.5x18mm" with a cost per unit of $115.47;
- "imp stry plt volar 2.7mm nrrw" as identified in the itemized statement and labeled on the invoice as "2.7mm xxl volar dr plate narrow" with a cost per unit of $1,653.12.

The total net invoice amount (exclusive of rebates and discounts) is $4,500.24. The total add-on amount of 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission is $450.02. The total recommended reimbursement amount for the implantable items is $4,950.26.

4. The total allowable reimbursement for the services in dispute is $4950.26. The amount previously paid by the insurance carrier is $6,854.69. The requestor is seeking additional reimbursement in the amount of $4,950.04. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $4.950.04.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $4,950.04 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		February 24, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.